REFERRAL FOR PSYCHIATRIC CONSULTATION

Corporate Office/Mail: 65 N. Highway 101 Suite 204 Warrenton, OR 97146
Fax: (503) 861-2043
Email: CBHReferrals@clatsopbh.org

Referral for Consultation Assessment Appointment: A one-time ONLY appointment. Referring clinician will accept all responsibility for care of identified client. CBH accepts consultation referrals for clients with the Oregon Health Plan, MODA, and Tricare Insurance.

Document checklist needed for consultation approval:

- ✓ **Release of information**
- ✓ **Most recent labs**
- ✓ **Pertinent recent chart notes**
- ✓ **List of prescribed medications**

Provider Information	
Facility Name:	
Facility Phone #:	**Facility Fax #:**
Referring Provider/PCP:	

Patient Information		
Patient Legal Name:		**DOB:**
Parent/Guardian (if applicable):		
Mailing Address:		
Home Phone / Cell#:		**Ok to leave message? Yes No**
Is an interpreter required? Yes No	**If yes, language / dialect:**	

Reason for consultation request? Please identify a specific question(s) that you would like answered as a result of this consultation.

Referring Provider / PCP must sign Agreement & Acknowledgement below:

I,_____retain medical liability and will continue to provide medical care to this patient. I understand the purpose of this referral is receive recommendations regarding psychiatric medication management from the providers at Clatsop Behavioral Healthcare after a one-time assessment appointment, the decision to implement these recommendations is mine.

_____

(Signature) (Date)